EXHIBIT A

Full-Time Employees

Apple Benefits Book

Effective January 2018

UBH000002

Contents

- UHC will pay benefits only to you or, with written authorization by you, your provider, and not to a third party, even if your provider has assigned benefits to that third party.

Late Charges and Collection Agency Fees
You have primary financial responsibility for payment of medical services. If payment of medical benefits is delayed, any late charges or collection agency fees are not covered. In case of delays for review, you should make payment arrangements with your provider to avoid collection proceedings and credit problems.

No Assignment
Amounts payable under the plan may be used to make direct payments to providers solely in the plan administrator's discretion. You cannot assign any benefits or monies due under the plan to any person, corporation, or organization. Assignment includes transferring your right to services covered by this plan or your right to collect payment for those services or to seek any remedy against the plan, to another person or organization. No benefit under the plan shall be subject in any way to assignment, alienation, sale, transfer, pledge, attachment, garnishment, exception, or encumbrance of any kind, and any attempt to accomplish the same shall be void.

Initial Claim Determinations

How and when a claim is processed depends on what type of claim it is. Health claims are generally divided into four categories: postservice claims, preservice claims, urgent claims, and concurrent care claims.

Postservice Claims
Postservice claims are those claims that are filed for payment of benefits after medical care has been received. If your postservice claim is denied, you will generally receive a written notice from UnitedHealthcare (UHC) within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UHC will notify you within this 30-day period if additional information is needed to process the claim, and UHC may request a one-time extension not longer than 15 days and pend your claim until all information is received or if otherwise necessary due to circumstances beyond UHC's control.

Once notified of the extension, you then have 45 days to provide the additional requested information, if applicable. The period for UHC to make a benefit determination will be suspended from the date you are notified of any additional requested information until the date you provide it. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the plan provision on which the denial is based, and provide the claim appeal procedures.

Preservice Claims
When prior authorization is suggested for medical care or prescription drugs, you will need to submit a preservice request to UHC. Obtaining prior authorization enables you to be better informed about what services your medical plan will cover and what it will pay for these services. If you filed a preservice request improperly, UHC will notify you of the improper filing and how to correct it within five days after the preservice request was received. If additional information is needed to process the preservice request, UHC will notify you of the information needed within 15 days after the request for service was received, and UHC may request a one-time extension not longer than 15 days and pend your request for service until all information is received or if otherwise necessary due to circumstances beyond UHC's control.

Once notified of the extension, you then have 45 days to provide the additional requested information, if applicable. The period for UHC to make a benefit determination will be suspended from the date you are notified of any additional requested information until the date you provide

Under the Apple STD Plan, Sedgwick is the claim fiduciary or "claims administrator" for STD benefits and has been delegated the discretionary authority to determine if you are eligible for disability benefits based on objective medical evidence. All decisions made by Sedgwick as claims administrator shall be final and binding on all participants and beneficiaries to the full extent permitted by law.

Authorization for Release and Use of Medical Information Form

For a claims examiner to handle your claim, you will need to sign an Authorization for Release and Use of Medical Information form, which will be mailed or emailed to you when you initiate your claim.

It is important to sign and return the Authorization for Release and Use of Medical Information form to Sedgwick as soon as you receive it. If you don't sign the medical release, the decision regarding your disability claim may be delayed, and your claim could be denied.

Claim Review Process

To determine approval for Apple STD Plan benefits, the claims examiner will work with your health care provider to obtain the necessary medical information. Medical information is due to Sedgwick within 20 calendar days from your first day absent from work or the date the claim is reported, whichever is later. In some situations, your claim may be reviewed by a Sedgwick nurse case manager and/or physician advisor. You may also be required to get an impartial medical examination at Apple's expense.

The claims examiner will notify you of the approval or denial of your Apple STD Plan claim within a reasonable period of time, but not later than 45 calendar days from the date the claim is received, unless extended as described below. If you prefiled your claim by contacting Sedgwick in advance of your disability, your claim will be deemed to have been received on your first day absent from work due to your disability. This period may be extended for up to 30 additional days, if necessary, due to matters beyond Apple's control. If such an extension is necessary, you will be notified before the expiration of the 45-day period of the reason for the extension and the date by which you can expect a decision.

The 30-day extension period also may be extended for up to 30 additional days, if necessary, due to matters beyond Apple's control. If this further extension is necessary, you will be notified before the end of the initial 30-day extension period of the reason for the extension and the date by which you can expect a decision.

When Benefits Begin

If you meet the eligibility requirements and if adequate supporting objective medical documentation is provided to Sedgwick to support your claim, Apple STD Plan benefits begin on the eighth consecutive calendar day of your disability.

Amount of Benefits

Benefits are based on your regular weekly pay effective on your first date of disability. Following the seven-day unpaid waiting period, the Apple STD Plan pays 100 percent of your regular pay for up to 12 weeks. Thereafter, the plan pays a benefit of 70 percent of your regular weekly pay for up to 13 additional weeks.

Benefits are payable on a seven-day workweek (one-seventh of the weekly benefits). Regular weekly pay is based on your standard weekly hours as shown in Merlin (Apple's HR information system) and includes base pay plus shift differential, if applicable. Overtime and bonuses are excluded. This amount includes all other sources of disability income.

If you are a commissioned employee, your regular weekly pay includes base pay and on-target variable. Overtime and bonuses are excluded. Refer to HRWeb for more information

How to Appeal a Denied Claim

Under the Apple LTD Plan, you must appeal a denied claim by making a written request to the LTD insurer within 180 days of the notice of your denial. You will lose your right to appeal if your written request is not postmarked within 180 days.

Your appeal letter should be addressed to the LTD insurance representative who signed the letter and to the address noted on the letterhead. You may also submit additional information, which may include, but is not limited to, medical records from your doctor and/or hospital, test result reports, therapy notes, and so forth.

See "Claims Information" on page 304 in the *General Information* section for information on how to appeal a denied LTD claim.

The LTD insurer is the claim fiduciary for LTD benefits and has the authority, in its discretion, to interpret the terms of the plan pertaining to benefits and to make any related findings of fact. All decisions made by the LTD insurer shall be final and binding on all participants and beneficiaries to the full extent permitted by law.

LTD Definitions

The Apple LTD Plan uses many specialized terms that may be included in communications sent by the LTD insurer. If you don't understand a term used to describe this benefit, see the LTD Certificate of Insurance on HRWeb for a listing of definitions.

General Information

Many laws govern benefits programs. This section contains detailed legal information and other general information that you and your family may need to know. It also includes information about how claims are reviewed, as well as your legal rights under the Employee Retirement Income Security Act (ERISA).

In any given year and during the course of your employment, Apple may make changes in these benefits programs, ranging from minor administrative revisions to larger strategic revisions, including termination of any benefits programs. Apple will notify you, when appropriate, of any changes.

Because of laws, government regulations, and the wide variety of possible exceptions to the situations described in this book, the information presented here is a summary of the most important provisions and most common situations associated with your benefits. While this book highlights the main features of Apple's benefits programs, it is not a comprehensive description.

In addition, since the law is subject to change by Congress and to interpretation by federal agencies and the courts, this summary may not always reflect the current status of the law. In case of any omission or conflict between this book and the official plan documents, contracts, or policies, the applicable plan documents, contracts, or policies, where applicable, will govern.

You are welcome to read the more detailed legal plan documents, contracts, and policies, where applicable, that govern your benefits programs. Contact the HR HelpLine at hrhelpline@apple.com, or call 800-473-7411 or 408-974-7411 for instructions on how to get these documents.

Administrative Information

Plan Sponsor
Apple Inc. is the employer and plan sponsor.

Plan Administrator
The Benefits Administrative Committee is the plan administrator with authority to control and manage the plans' operations. Communication to the Plan Administrator should be addressed to the following:

Apple Inc.
Benefits Administrative Committee
One Apple Park Way, MS 104-1BEN
Cupertino, CA 95014
Attention: Apple Benefits
800-473-7411
408-974-7411

Apple's Employer Identification Number is 94-2404110.

A list of the Apple-designated affiliates that participate in each of the plans is available by writing to the address listed earlier.

Plan Administration

The Benefits Administrative Committee (or its authorized delegate) is the plan administrator for each plan has the sole and absolute discretionary authority to construe and interpret the plan, supply omissions, correct any defect, and determine all questions regarding the eligibility for as well as the amount of benefits. In this regard, the plan administrator's decisions shall be conclusive and binding on all persons. The failure of the plan administrator to require or enforce the strict performance of any provision of a plan or to exercise any right or authority under the plan will not be construed as a waiver or relinquishment to any extent of the plan administrator's right to assert or rely upon any such provision or right in that or any other instance.

No individual other than the plan administrator and those that have been specifically authorized by the plan administrator to act on its behalf has any authority to interpret any plan, including any provision in this book, or to make any promises to you about any benefits or to change any provision of any plan.

For information regarding delegation of administrative duties, make a written request to:

Apple Inc.
Benefits Administrative Committee
One Apple Park Way, MS 104-1BEN
Cupertino, CA 95014
Attention: Apple Benefits

Plan Amendment and Termination

Although Apple hopes to continue the plans, policies, and programs described here, this may not always be the case. Therefore, Apple reserves the right to change or terminate these plans, policies, and programs at any time, for any reason, without advance notice.

Other Information

The following section describes other important provisions applicable to Apple's benefits plans.

Eligibility and Coverage

If you have any questions about whether you are eligible for any of the benefits described here or the benefits plans themselves, contact the HR HelpLine at hrhelpline@apple.com, or call 800-473-7411 or 408-974-7411.

Independent contractors, consultants, and temporary agency workers are not eligible for any of the health care plans or financial programs described in this book.

If you were an independent contractor, consultant, or temporary agency worker before being hired as a standard Apple employee or intern, none of your service in that capacity will be taken into consideration for any purpose under any Apple benefits plan or program (with the exception of eligibility for the Family and Medical Leave Act, in some cases).

Protection of Personal Health Information

During the process of administering the Apple Health and Welfare Benefit Plan, Apple Benefits may receive personal health information from you or a family member. Apple recognizes the importance of privacy when this occurs and, in conformance with federal laws, has established policies to limit the amount of information it receives and to protect your personal health information from unauthorized access and use.

See HRWeb to view a copy of the Apple Health and Welfare Benefit Plan Notice of Health Information Privacy Practices, which describes how the plan may use and disclose protected health information (PHI) about you in administering your benefits and your legal rights regarding PHI. You will be notified at least once

every three years of the plan's privacy practices. You will also be notified within 60 days of any material change to the plan's privacy practices.

Inspection of Documents

You may examine, without charge, at Apple, all plan documents, including insurance contracts and copies of all documents filed by the plan with the US Department of Labor, such as detailed annual reports and plan descriptions.

You can also get copies of all plan documents and other plan information upon written request to the plan administrator at:

Apple Inc.
One Apple Park Way, MS 104-1BEN
Cupertino, CA 95014
Attention: Apple Benefits

Apple may charge a reasonable fee for the copies.

No Right to Employment

Nothing in Apple's benefits plans gives you a right to remain in employment or affects Apple's right to terminate your employment at any time and for any reason—that right is hereby reserved.

Claims Information

This section provides information on Apple's claims filing and appeals processes.

Claims Filing Procedures for the Apple Health and Welfare Benefit Plan and Educational Assistance Program

A claim is a request for a plan benefit by a participant or beneficiary. The party responsible for processing the claim depends on the benefit option and the nature of the claim. With regard to self-funded plans and Flexible Spending Accounts, the plan administrator has delegated authority to review claims and appeals to the plans' claims administrators:

Medical Claims Administrator:

UnitedHealthcare
Appeals and Grievances
P.O. Box 740800
Atlanta, GA 30374-0800

Dental Claims Administrator:

MetLife Group Claims Review
P.O. Box 14589
Lexington, KY 40512

Vision Claims Administrator:

Vision Service Plan
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

Short Term Disability Claims Administrator:

Sedgwick Leave Service Center
Appeals Unit
P.O. Box 14424
Lexington, KY 40512-4424

The insurance companies and Kaiser are responsible for processing claims for benefits under their respective benefits, including claims for eligibility for specific benefits. Claim procedures for the insured benefit options or Kaiser, which will be administered in a manner consistent with the claims procedure requirements, are set forth in the applicable insurance policy or evidence of coverage. All other claims will follow the procedures set forth in this section.

The plan administrator (or its delegate) for each plan has the sole and absolute discretionary authority to construe and interpret the plan, supply omissions, correct any defect, and determine all questions regarding eligibility for as well as the amount of benefits. In this regard, the plan administrator's decisions shall be

conclusive and binding on all persons. Decisions shall be made in accordance with the governing plan documents, and where appropriate, plan provisions will be applied consistently with respect to similarly situated claimants in similar circumstances. The plan administrator shall have the discretion to determine which claimants are similarly situated in similar circumstances. Benefits will be paid only if the plan administrator or its delegate determines, in its discretion, that the applicant is entitled to them.

Claims for benefits under the self-funded Apple medical, vision, and dental plans, short-term disability, or the Flexible Spending Accounts should be submitted to the respective claims administrator.

Claims for Kaiser, the Hawaii Medical Service Association (HMSA) PPO Plan, Cigna Global Medical and Dental Plans, the Apple Long-Term Disability Insurance Plan, and Medical Benefits Abroad Plan should be submitted directly to the applicable insurance company.

Contact the HR HelpLine regarding claims and appeals for certain insured benefits, including life insurance, Accidental Death & Dismemberment, and Business Travel Accident Insurance.

See "Plan Information" on page 315 for the list of claims administrators and insurers for Apple's plans.

Denial of Claims and Benefits Appeal Process

The procedures for submitting and receiving determinations on initial claims for benefits are covered in the applicable sections of this book. If a claim is denied and you disagree with the decision, you should review the Health Statement or Explanation of Benefits to see if there is an error. You may contact the appropriate claims administrator's member services or customer service department to discuss how it can be corrected. You may be able to provide additional information over the phone that may help in the review of your claim. See "Plan Information" on page 315 for the chart listing the claims administrator or insurer for each of Apple's plans.

If your claim is denied, you have the right to appeal the decision. This section reviews the process for appealing claims denied under the Apple Health and Welfare Benefit Plan and the Flexible Spending Accounts. These procedures apply unless otherwise specified in this or another section of the Benefits Book.

Claimant Representatives

You may designate an authorized representative, an individual authorized to act on your behalf in pursuing a claim or appeal, for assistance with respect to your claim for benefits. (Note: For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative, even without a formal designation from you.) If you wish to do so, contact the claim administrator for more information on what you'll need to do to designate an authorized representative, including executing a written authorization form provided by the Plan. The claim administrator will not respond to any individual or entity who has attempted to file a claim or appeal on behalf of a claimant who has not been validly designated as an authorized representative by the claims administrator in accordance with the Plan rules.

Initial Claim Determinations

How and when a claim is processed depends on what type of claim it is.

Health Claims

Health claims are generally divided into four categories: postservice claims, preservice claims, urgent care claims, and concurrent care claims.